

# EMORY JOHNS CREEK HOSPITAL



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## FACSIMILE TRANSMITTAL

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TO:	PRE-REGISTRATION SERVICES	PATIENT NAME:	
COMPANY:	EMORY JOHNS CREEK HOSPITAL	DATE:	
FAX NUMBER:	678-474-7086	TOTAL NO. OF PAGES INCLUDING COVER:	
PHONE NUMBER:	678-474-7084	PATIENT PHONE NUMBER::	
RE:	PATIENT PRE-REGISTRATION	PATIENT ALTERNATE PHONE NUMBER:	

NOTES/COMMENTS:

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6325 West Johns Crossing  
Duluth, GA 30097

Pre- Admission Form

Fax to : (678) 474-7086

**Please complete this form and have information ready for pre-admission registration.**

*If patient is responsible party do not complete Guarantor section.*

Date to be Admitted/Surgery		If Maternity Patient, Fill Expected Date of Delivery						
Surgery Time								
Admitting Physician								
Please Make Any Necessary Name or Address Corrections								
<b>PATIENT INFORMATION</b>	Patient's Name (Last) (First) (Middle)			Date of Birth	Age	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated		<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
	Home Address		City	State	Zip Code	County		
	Home Phone		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Religious Preference		Patient Social Security Number		
	Patient's Employer			Employer's Address		Phone Number		
	Patient's Occupation			Previous Admission Date		Previous Admission Name (If Different)		
	Nearest Relative at Different Address			Relationship	Address		Phone Number	
	Notify in Case of Emergency			Relationship	Address		Phone Number	
<b>GUARANTOR</b>	Person Responsible for Bill (Last) (First) (Middle)			Social Security Number		Phone Number		
	Guarantor Address		City	State	Zip	Occupation		
	Guarantor's Employer			Employer's Address		Phone Number		
<b>INSURANCE</b>	Medicare Number			Name as it Appears on Medicare Card		Has Patient Been Hospitalized within 60 Days of the Scheduled Admission Date? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Medicare Case Number 3 Digits      6 Digits      2 Digits      2 Digits			Has Patient Been Hospitalized within 45 Days of the Scheduled Admission Date? <input type="checkbox"/> Yes <input type="checkbox"/> No		Case Worker	Policy Number	
	Blue Cross Group		Blue Cross Contract Number		Location of Plan-City, State		Contract Holder	Social Security Number
	Policy One	Policy Number		Insurance Company and Address			Policy Holder	Social Security Number
		If Group, Name of Employer			Employer's Address		Employer's Phone	
	Policy Two	Policy Number		Insurance Company and Address			Policy Holder	Social Security Number
		If Group, Name of Employer			Employer's Address		Employer's Phone	

**Complete esta forma y tenga sus documentos preparados para registrarse.**

*If patient is responsible party do not complete Guarantor section.*

	Fecha de Cirujia	Si viene para maternidad cuando se aliviara?	Ha usted aplicado para Medicaid?				
	Surgery Time		En que condado _____ Nombre del agente _____				
	Admitting Physician		Agente # de Telefono _____				
			Please Make Any Necessary Name or Address Corrections				
<b>PATIENT INFORMATION</b>	Apellido del Paciente	Nombre	Inicial	Fecha de Nacimiento	Edad	<input type="checkbox"/> Soltero <input type="checkbox"/> Casado <input type="checkbox"/> Separado	<input type="checkbox"/> Divorciado <input type="checkbox"/> Viudo
	Direccion de Su Casa		Ciudad	Estado	Codigo Postal	Condado	
	Telefono de Su Casa	Sex	Religious Preference		Patient Social Security Number Numero del Seguro Social del Paciente		
	Para Quien Trabaja	<input type="checkbox"/> Male <input type="checkbox"/> Female	Direccion de Su Trabajo			Numero de Telefono	
	Ocupacion del Paciente	Previous Admission Date			Ha usted sido admitido antes?		
	Nombre de un Familiar	Relacion	Direccion			Numero de Telefono	
	A quien se le notifica en caso de emergencia?	Relacion	Direccion			# de Telefono	
<b>GUARANTOR</b>	Responsable del pago de la cuenta apellido nombre	Nombre	Inicial	Seguro Social	# de Telefono		
	Guarantor Address	Ciudad	Estado	Codigo Postal	Occupation		
	Direccion de la persona responsable	Direccion de el empleador			# de Telefono		
<b>INSURANCE</b>	Numero de Medicare	Nombre de la persona en la tarjeta de Medicare			Ha Sido Usted Hospitalizado 60 Dias Antes de su cita original? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Medicare # de Caso	3 digitos	6 digitos	2 digitos	2 digitos	Ha Sido Usted Hospitalizado 45 Dias Antes de su cita original? <input type="checkbox"/> Yes <input type="checkbox"/> No	Agente # De Poliza
	Blue Cross Grupo	Blue Cross # de Contrato			Ciudad & estado del plan	Poliza a nombre de?	# Seguro Social
	Policy One	# De Poliza	Nombre de aseguradora			Poliza a nombre de?	# Seguro Social
	Policy One	Grupo? Nombre del Empleador			Direccion del Empleador		Empleador # del Telefono
	Policy Two	# De Poliza	Nombre de la a segurador			Poliza a nombre de?	# Seguro Social
Policy Two	Grupo? Nombre del Empleador			Direccion del Empleador		Empleador # del Telefono	